

1 3574 3574 CERTIFICATE OF DEATH

03540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>25 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIO-VISTA NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL</u> <u>Rudolph</u> <u>BARNES</u>				4. DATE OF DEATH Month Day Year <u>MAR</u> <u>4</u> <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 15 1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>11</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIME KEEPER (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STATE Road</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>JAMES JOSEPH BARNES</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA PLUMMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Elizabeth Barnes St Michaels</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic cardiovascular d.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>53</u> , to <u>3-4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-4</u> , 19 <u>59</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Guy M Reeser Jr</u> M.D. <u>St Michaels md</u> PHYSICIAN'S NAME (Type) <u>3-6-59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 7-1959</u>		<u>Christ Cemetery</u>		<u>St Michaels md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Hamilton Harrison St Michaels</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
19. SIGNATURE OF CORONER <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JUDGE <i>John Doe</i>	
22. SIGNATURE OF CLERK <i>John Doe</i>		23. SIGNATURE OF REGISTRAR <i>John Doe</i>		24. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT <i>John Doe</i>		26. SIGNATURE OF CHIEF <i>John Doe</i>		27. SIGNATURE OF DEPUTY <i>John Doe</i>	
28. SIGNATURE OF SECRETARY <i>John Doe</i>		29. SIGNATURE OF CLERK <i>John Doe</i>		30. SIGNATURE OF ARCHIVIST <i>John Doe</i>	
31. SIGNATURE OF REGISTRAR <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JUDGE <i>John Doe</i>	
34. SIGNATURE OF CLERK <i>John Doe</i>		35. SIGNATURE OF ARCHIVIST <i>John Doe</i>		36. SIGNATURE OF DEPUTY <i>John Doe</i>	
37. SIGNATURE OF SECRETARY <i>John Doe</i>		38. SIGNATURE OF CHIEF <i>John Doe</i>		39. SIGNATURE OF DEPUTY <i>John Doe</i>	
40. SIGNATURE OF ASSISTANT <i>John Doe</i>		41. SIGNATURE OF CHIEF <i>John Doe</i>		42. SIGNATURE OF DEPUTY <i>John Doe</i>	
43. SIGNATURE OF SECRETARY <i>John Doe</i>		44. SIGNATURE OF CHIEF <i>John Doe</i>		45. SIGNATURE OF DEPUTY <i>John Doe</i>	
46. SIGNATURE OF ASSISTANT <i>John Doe</i>		47. SIGNATURE OF CHIEF <i>John Doe</i>		48. SIGNATURE OF DEPUTY <i>John Doe</i>	
49. SIGNATURE OF SECRETARY <i>John Doe</i>		50. SIGNATURE OF CHIEF <i>John Doe</i>		51. SIGNATURE OF DEPUTY <i>John Doe</i>	
52. SIGNATURE OF ASSISTANT <i>John Doe</i>		53. SIGNATURE OF CHIEF <i>John Doe</i>		54. SIGNATURE OF DEPUTY <i>John Doe</i>	
55. SIGNATURE OF SECRETARY <i>John Doe</i>		56. SIGNATURE OF CHIEF <i>John Doe</i>		57. SIGNATURE OF DEPUTY <i>John Doe</i>	
58. SIGNATURE OF ASSISTANT <i>John Doe</i>		59. SIGNATURE OF CHIEF <i>John Doe</i>		60. SIGNATURE OF DEPUTY <i>John Doe</i>	
61. SIGNATURE OF SECRETARY <i>John Doe</i>		62. SIGNATURE OF CHIEF <i>John Doe</i>		63. SIGNATURE OF DEPUTY <i>John Doe</i>	
64. SIGNATURE OF ASSISTANT <i>John Doe</i>		65. SIGNATURE OF CHIEF <i>John Doe</i>		66. SIGNATURE OF DEPUTY <i>John Doe</i>	
67. SIGNATURE OF SECRETARY <i>John Doe</i>		68. SIGNATURE OF CHIEF <i>John Doe</i>		69. SIGNATURE OF DEPUTY <i>John Doe</i>	
70. SIGNATURE OF ASSISTANT <i>John Doe</i>		71. SIGNATURE OF CHIEF <i>John Doe</i>		72. SIGNATURE OF DEPUTY <i>John Doe</i>	
73. SIGNATURE OF SECRETARY <i>John Doe</i>		74. SIGNATURE OF CHIEF <i>John Doe</i>		75. SIGNATURE OF DEPUTY <i>John Doe</i>	
76. SIGNATURE OF ASSISTANT <i>John Doe</i>		77. SIGNATURE OF CHIEF <i>John Doe</i>		78. SIGNATURE OF DEPUTY <i>John Doe</i>	
79. SIGNATURE OF SECRETARY <i>John Doe</i>		80. SIGNATURE OF CHIEF <i>John Doe</i>		81. SIGNATURE OF DEPUTY <i>John Doe</i>	
82. SIGNATURE OF ASSISTANT <i>John Doe</i>		83. SIGNATURE OF CHIEF <i>John Doe</i>		84. SIGNATURE OF DEPUTY <i>John Doe</i>	
85. SIGNATURE OF SECRETARY <i>John Doe</i>		86. SIGNATURE OF CHIEF <i>John Doe</i>		87. SIGNATURE OF DEPUTY <i>John Doe</i>	
88. SIGNATURE OF ASSISTANT <i>John Doe</i>		89. SIGNATURE OF CHIEF <i>John Doe</i>		90. SIGNATURE OF DEPUTY <i>John Doe</i>	
91. SIGNATURE OF SECRETARY <i>John Doe</i>		92. SIGNATURE OF CHIEF <i>John Doe</i>		93. SIGNATURE OF DEPUTY <i>John Doe</i>	
94. SIGNATURE OF ASSISTANT <i>John Doe</i>		95. SIGNATURE OF CHIEF <i>John Doe</i>		96. SIGNATURE OF DEPUTY <i>John Doe</i>	
97. SIGNATURE OF SECRETARY <i>John Doe</i>		98. SIGNATURE OF CHIEF <i>John Doe</i>		99. SIGNATURE OF DEPUTY <i>John Doe</i>	
100. SIGNATURE OF ASSISTANT <i>John Doe</i>		101. SIGNATURE OF CHIEF <i>John Doe</i>		102. SIGNATURE OF DEPUTY <i>John Doe</i>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>240. Harrison St</u>	
3. NAME OF DECEASED (Type or print) <u>E. Virginia Baynard</u>		4. DATE OF DEATH <u>March 26</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1913</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR: Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Baynard</u>		14. MOTHER'S MAIDEN NAME <u>Katie Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-65-6274</u>	
17. INFORMANT <u>John I. Baynard</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of ovaries</u> DUE TO (c) <u>27 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>58</u> , to <u>3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/11/59</u> , 19 <u>59</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>Arthur S. Thomas</u>			
ACTUAL SIGNATURE <u>J. Tyler Baker</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. T. BAKER</u> <u>EASTON MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 27, 59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

03542

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>16 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TERRIE</u> Middle <u>LYNN</u> Last <u>Biskach</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank C. Biskach</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Patricia Biskach (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>763.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Anoxia</u> (c) <u>Hemorrhagic Pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>16 hrs</u> <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-19</u> , 19 <u>55</u> , to <u>3-19</u> , 19 <u>55</u> that I last saw the deceased alive on <u>3-19</u> , 19 <u>55</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Biskach</u>		ADDRESS (Street, city or town, state) <u>205 Earle Ave Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E. BISKACH</u>		DATE SIGNED <u>3-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eldorado Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eldorado Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton</u>		ADDRESS <u>and Son Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	

MAR-14 MD STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 09X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D #1</u>			
3. NAME OF DECEASED (Type or print) <u>MARY Frances</u> First <u>X</u> Middle <u>BRIAN</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22 1915</u> 43 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry M. Klickerson</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-2344</u>		17. INFORMANT <u>CARLTON BRIAN - husband - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Idiopathic dilatation and hypertrophy of the heart</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>3+ yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-16</u> , 19 <u>59</u> , to <u>3-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-19</u> , 19 <u>59</u> , and that death occurred at <u>10</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.				DATE SIGNED <u>202 Dover St.</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>				Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLD SCHOOL BAPTIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR LAUREL, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frayton Son, Federalburg Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3549

CERTIFICATE OF DEATH

Reg. Dist. No.

03544

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marcellus</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1904</u>
9. AGE (In years last birth day) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>1959</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcellus Brown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alice Brown, wife — same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage with intra-ventricular and subarachnoid extension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-10</u> , 19 <u>59</u> , to <u>3-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>59</u> , and that death occurred at <u>1:40</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>3-13-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>		Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Holshorn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Trever</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 16 '59</u>		<u>Charles E. Trever</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1918</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Massachusetts</i></p>	
<p>10. OCCUPATION <i>Teacher</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. PREVIOUS ILLNESS <i>None</i></p>		<p>14. MEDICAL HISTORY <i>None</i></p>		<p>15. SURVIVAL OF OTHERS <i>Yes</i></p>	
<p>16. SIGNATURE OF PHYSICIAN <i>Dr. J. A. Smith</i></p>		<p>17. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>19. SIGNATURE OF WITNESSES <i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>21. SIGNATURE OF DECEASED <i>John Doe</i></p>	



3575

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>50 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BETHINE</u> Middle <u>ALMOND</u> Last <u>BUCK</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1883</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES A. CRISCI</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EDWARD R. BUCK, WEST FALMOUTH, MASS.</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary Artery, Hard Dis</u> DUE TO (c) <u>59.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleurothoritis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lane Wroth</u>				ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>				DATE SIGNED <u>3-5-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Cawell</u>				ADDRESS <u>ST. MICHAELS MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

1. NAME OF DECEASED [Faint text, possibly "John Doe"]		2. SEX [Faint text, possibly "Male"]		3. AGE [Faint text, possibly "45"]		4. DATE OF BIRTH [Faint text, possibly "Jan 1, 1872"]	
5. PLACE OF BIRTH [Faint text, possibly "Maryland"]		6. OCCUPATION [Faint text, possibly "Farmer"]		7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		8. PLACE OF DEATH [Faint text, possibly "Home"]	
9. DATE OF DEATH [Faint text, possibly "Dec 15, 1917"]		10. TIME OF DEATH [Faint text, possibly "10:00 AM"]		11. SIGNATURE OF PHYSICIAN [Faint signature]		12. SIGNATURE OF REGISTRAR [Faint signature]	
13. SIGNATURE OF WITNESS [Faint signature]		14. SIGNATURE OF WITNESS [Faint signature]		15. SIGNATURE OF WITNESS [Faint signature]		16. SIGNATURE OF WITNESS [Faint signature]	
17. SIGNATURE OF WITNESS [Faint signature]		18. SIGNATURE OF WITNESS [Faint signature]		19. SIGNATURE OF WITNESS [Faint signature]		20. SIGNATURE OF WITNESS [Faint signature]	
21. SIGNATURE OF WITNESS [Faint signature]		22. SIGNATURE OF WITNESS [Faint signature]		23. SIGNATURE OF WITNESS [Faint signature]		24. SIGNATURE OF WITNESS [Faint signature]	
25. SIGNATURE OF WITNESS [Faint signature]		26. SIGNATURE OF WITNESS [Faint signature]		27. SIGNATURE OF WITNESS [Faint signature]		28. SIGNATURE OF WITNESS [Faint signature]	
29. SIGNATURE OF WITNESS [Faint signature]		30. SIGNATURE OF WITNESS [Faint signature]		31. SIGNATURE OF WITNESS [Faint signature]		32. SIGNATURE OF WITNESS [Faint signature]	
33. SIGNATURE OF WITNESS [Faint signature]		34. SIGNATURE OF WITNESS [Faint signature]		35. SIGNATURE OF WITNESS [Faint signature]		36. SIGNATURE OF WITNESS [Faint signature]	
37. SIGNATURE OF WITNESS [Faint signature]		38. SIGNATURE OF WITNESS [Faint signature]		39. SIGNATURE OF WITNESS [Faint signature]		40. SIGNATURE OF WITNESS [Faint signature]	
41. SIGNATURE OF WITNESS [Faint signature]		42. SIGNATURE OF WITNESS [Faint signature]		43. SIGNATURE OF WITNESS [Faint signature]		44. SIGNATURE OF WITNESS [Faint signature]	
45. SIGNATURE OF WITNESS [Faint signature]		46. SIGNATURE OF WITNESS [Faint signature]		47. SIGNATURE OF WITNESS [Faint signature]		48. SIGNATURE OF WITNESS [Faint signature]	
49. SIGNATURE OF WITNESS [Faint signature]		50. SIGNATURE OF WITNESS [Faint signature]		51. SIGNATURE OF WITNESS [Faint signature]		52. SIGNATURE OF WITNESS [Faint signature]	
53. SIGNATURE OF WITNESS [Faint signature]		54. SIGNATURE OF WITNESS [Faint signature]		55. SIGNATURE OF WITNESS [Faint signature]		56. SIGNATURE OF WITNESS [Faint signature]	
57. SIGNATURE OF WITNESS [Faint signature]		58. SIGNATURE OF WITNESS [Faint signature]		59. SIGNATURE OF WITNESS [Faint signature]		60. SIGNATURE OF WITNESS [Faint signature]	
61. SIGNATURE OF WITNESS [Faint signature]		62. SIGNATURE OF WITNESS [Faint signature]		63. SIGNATURE OF WITNESS [Faint signature]		64. SIGNATURE OF WITNESS [Faint signature]	
65. SIGNATURE OF WITNESS [Faint signature]		66. SIGNATURE OF WITNESS [Faint signature]		67. SIGNATURE OF WITNESS [Faint signature]		68. SIGNATURE OF WITNESS [Faint signature]	
69. SIGNATURE OF WITNESS [Faint signature]		70. SIGNATURE OF WITNESS [Faint signature]		71. SIGNATURE OF WITNESS [Faint signature]		72. SIGNATURE OF WITNESS [Faint signature]	
73. SIGNATURE OF WITNESS [Faint signature]		74. SIGNATURE OF WITNESS [Faint signature]		75. SIGNATURE OF WITNESS [Faint signature]		76. SIGNATURE OF WITNESS [Faint signature]	
77. SIGNATURE OF WITNESS [Faint signature]		78. SIGNATURE OF WITNESS [Faint signature]		79. SIGNATURE OF WITNESS [Faint signature]		80. SIGNATURE OF WITNESS [Faint signature]	
81. SIGNATURE OF WITNESS [Faint signature]		82. SIGNATURE OF WITNESS [Faint signature]		83. SIGNATURE OF WITNESS [Faint signature]		84. SIGNATURE OF WITNESS [Faint signature]	
85. SIGNATURE OF WITNESS [Faint signature]		86. SIGNATURE OF WITNESS [Faint signature]		87. SIGNATURE OF WITNESS [Faint signature]		88. SIGNATURE OF WITNESS [Faint signature]	
89. SIGNATURE OF WITNESS [Faint signature]		90. SIGNATURE OF WITNESS [Faint signature]		91. SIGNATURE OF WITNESS [Faint signature]		92. SIGNATURE OF WITNESS [Faint signature]	
93. SIGNATURE OF WITNESS [Faint signature]		94. SIGNATURE OF WITNESS [Faint signature]		95. SIGNATURE OF WITNESS [Faint signature]		96. SIGNATURE OF WITNESS [Faint signature]	
97. SIGNATURE OF WITNESS [Faint signature]		98. SIGNATURE OF WITNESS [Faint signature]		99. SIGNATURE OF WITNESS [Faint signature]		100. SIGNATURE OF WITNESS [Faint signature]	

This certificate is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be filled out in duplicate, and the original is to be filed in the office of the Registrar, and the duplicate is to be filed in the office of the physician or other person who has attended the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG240 3-30-59 et

CERTIFICATE OF DEATH

03546

Reg. Dist. No.

3576

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>	c. LENGTH OF STAY IN 1b <u>26 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>P.</u> Last <u>Cassidy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal & Ship Repairs</u>	9. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William A. Cassidy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Beaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>M. J. P. Cassidy</u> Address <u>Easton, Md. P.O.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic essential hypertension, obesity</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>46</u> , to <u>21 Mar</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 Mar</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Easton Maryland</u> <u>23 Mar 59</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	22b. DATE THEREOF <u>Mar 23, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King's Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Huns</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

ARMY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03547

CERTIFICATE OF DEATH

Reg. Dist. No.

3550

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Ronald</u> Last <u>Dean</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 22, 1956</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Neal Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u> </u> Address <u> </u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute septice meningitis</u> <u>082.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>79 S. Washington St. Easton Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>13 Mar 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/55</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Roswell</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

CERTIFICATE OF DEATH

3550

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. DOWD		MALE		65		JAN 15 1885		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		JAN 20 1950		BALTIMORE		MD		MD	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE	
HIGH SCHOOL		CATHOLIC		1905		BALTIMORE		MD		MD		MD		MD	
FATHER'S NAME		MOTHER'S NAME		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAMES M. DOWD		MARY M. DOWD		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
RETIRED		RETIRED		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAN 15 1885		JAN 15 1885		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
BALTIMORE		BALTIMORE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S STATE		MOTHER'S STATE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
MD		MD		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S COUNTRY		MOTHER'S COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
USA		USA		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RACE		MOTHER'S RACE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
WHITE		WHITE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RELIGION		MOTHER'S RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
CATHOLIC		CATHOLIC		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
1905		1905		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
BALTIMORE		BALTIMORE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S STATE OF MARRIAGE		MOTHER'S STATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
MD		MD		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S COUNTRY OF MARRIAGE		MOTHER'S COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
USA		USA		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RACE OF MARRIAGE		MOTHER'S RACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
WHITE		WHITE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RELIGION OF MARRIAGE		MOTHER'S RELIGION OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
CATHOLIC		CATHOLIC		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
1905		1905		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
BALTIMORE		BALTIMORE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S STATE OF MARRIAGE		MOTHER'S STATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
MD		MD		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S COUNTRY OF MARRIAGE		MOTHER'S COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
USA		USA		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RACE OF MARRIAGE		MOTHER'S RACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
WHITE		WHITE		JAN 20 1950		BALTIMORE		MD		MD		USA			
FATHER'S RELIGION OF MARRIAGE		MOTHER'S RELIGION OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
CATHOLIC		CATHOLIC		JAN 20 1950		BALTIMORE		MD		MD		USA			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3551

CERTIFICATE OF DEATH

04776
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Benjamin Friend</u>				4. DATE OF DEATH Month Day Year <u>3 26 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 25, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>DORA QUICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>171-17-1503</u>		17. INFORMANT <u>MRS. ETHEL FRIEND - EASTON, MD.</u> Address <u>"LIFTON"</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>March 26</u> , 1959, that I last saw the deceased alive on <u>March 26</u> , 1959, and that death occurred at <u>9:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>971 Harmon St. Easton, Md.</u>		DATE SIGNED <u>3-26-59</u>	
PHYSICIAN'S NAME (Type) <u>Donald A. Bartley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OXFORD MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald A. Bartley</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur P. Hays</u>	

CERTIFICATE OF DEATH

3251

PLACE OF DEATH HOME		SEX MALE		AGE 25	
CITY OR TOWN BOSTON		COUNTY SUFFOLK		STATE MASSACHUSETTS	
DECEASED JOHN J. BROWN		OCCUPATION LABORER		DATE OF DEATH JAN 10 1900	
CAUSE OF DEATH DISEASE OF THE HEART		MODE OF DEATH NATURAL		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF PHYSICIAN J. J. BROWN		SIGNATURE OF CLERK J. J. BROWN		SIGNATURE OF WITNESSES J. J. BROWN	
REGISTERED J. J. BROWN		INDEXED J. J. BROWN		FILED J. J. BROWN	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3577

CERTIFICATE OF DEATH

03540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels Rural</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X - St Michaels - Rural</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph A. Gamble</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>30</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Congressman</u>	
11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert J. Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Carrie O. Abernethy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-40-3651A</u>	
17. INFORMANT <u>Mrs Ralph Gamble</u>		Address <u>St Michaels Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cachexia severe</u> DUE TO (c) <u>adenocarcinoma pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wks</u> <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>with generalized metastases - lung - abd</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-59</u> , to <u>3-4-59</u> , that I last saw the deceased alive on <u>3-4-59</u> , and that death occurred at <u>2:50</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ray M Reeser Jr</u>		ADDRESS (Street, city or town, state) <u>St Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>Ray M Reeser Jr</u>		DATE SIGNED <u>3-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 6, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>		ADDRESS <u>108 S. Harrison St. Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1918

THE MARYLAND STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
JAN 10 1918

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Brown		Male		45		Jan 10 1918		Baltimore, Md.	
Cause of Death		Disease		Duration		Time of Day		Month	
Pneumonia		Pneumonia		10 days		10:00 AM		January	
Place of Birth		Occupation		Marital Status		Previous Illness		Signature of Physician	
Baltimore, Md.		Teacher		Married		None		J. H. Smith, M.D.	
Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Priest		Signature of Undertaker	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

3552

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Tacket</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Tacket</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		1 d. STREET ADDRESS <u>Salisbury Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ALICE GAREY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>M. Elizabeth Plummer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>H. E. G. Garey</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/24</u> , 19 <u>59</u> , to <u>3/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. E. G. Garey</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>3/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Mar 30, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Carter</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Robert B. Carter</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: <u>WILLIAM</u></p>		<p>2. SEX: <u>MALE</u></p>	
<p>3. AGE: <u>70</u></p>		<p>4. DATE OF BIRTH: <u>1900</u></p>	
<p>5. PLACE OF BIRTH: <u>NEW YORK</u></p>		<p>6. OCCUPATION: <u>LABORER</u></p>	
<p>7. MARITAL STATUS: <u>MARRIED</u></p>		<p>8. DATE OF MARRIAGE: <u>1920</u></p>	
<p>9. NAME OF SPOUSE: <u>MARY</u></p>		<p>10. DATE OF DEATH: <u>1970</u></p>	
<p>11. PLACE OF DEATH: <u>HOME</u></p>		<p>12. CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>13. MEDICAL HISTORY: <u>NO</u></p>		<p>14. SIGNATURE OF PHYSICIAN: <u>[Signature]</u></p>	
<p>15. SIGNATURE OF WITNESS: <u>[Signature]</u></p>		<p>16. SIGNATURE OF REGISTRAR: <u>[Signature]</u></p>	
<p>17. DATE OF REGISTRATION: <u>1970</u></p>		<p>18. OFFICE OF REGISTRATION: <u>BALTIMORE</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 3553 03551 Reg. Dist. No. 1. PLACE OF DEATH o. COUNTY Talbot MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b 5 days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro 051-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 3. NAME OF DECEASED (Type or print) First Middle Last William R Gray 4. DATE OF DEATH Month Day Year March 1 19 59 5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH December 23, 1899 79 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME Robert Henry Gray 14. MOTHER'S MAIDEN NAME Mary Ann Reed 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No 16. SOCIAL SECURITY NO. None 17. INFORMANT Russell W. Gray Langley, G. F. B. Va. Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 449X Epoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1st CVD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 2/25/59, 19 59, to 3/1/59, 19 59, that I last saw the deceased alive on 3/1/59, 19 59, and that death occurred at 6:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE PF Cox M.D. M.D. Easton Md. DATE SIGNED 3/2/59 PHYSICIAN'S NAME (Type) P F COX M.D. Easton Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/4/59 22c. NAME OF CEMETERY OR CREMATORY Arlington 22d. LOCATION (City, town, or county) (State) Wreath Hill Pa. 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boule's Greensboro, Md. ADDRESS 24a. REC'D BY REGISTRAR DATE MAR 4 59 24b. REGISTRAR'S SIGNATURE Arthur S. Smith VS A15 (4) 15M 9/55

CERTIFICATE OF DEATH

6255

<p>1. Name of deceased (Print or write full name) <i>John C. V.D.</i></p>		<p>2. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Date of birth <i>1900</i></p>		<p>4. Place of birth <i>MD</i></p>	
<p>5. Date of death <i>1900</i></p>		<p>6. Place of death <i>MD</i></p>	
<p>7. Cause of death (Print or write full name) <i>Heart Disease</i></p>		<p>8. Immediate cause of death (Print or write full name) <i>Heart Disease</i></p>	
<p>9. Duration of illness (Print or write full name) <i>10 days</i></p>		<p>10. Name of attending physician (Print or write full name) <i>Dr. J. C. V.D.</i></p>	
<p>11. Name of funeral home (Print or write full name) <i>John C. V.D.</i></p>		<p>12. Name of undertaker (Print or write full name) <i>John C. V.D.</i></p>	
<p>13. Name of cemetery (Print or write full name) <i>John C. V.D.</i></p>		<p>14. Name of burial place (Print or write full name) <i>John C. V.D.</i></p>	
<p>15. Name of registrar (Print or write full name) <i>John C. V.D.</i></p>		<p>16. Name of registrar (Print or write full name) <i>John C. V.D.</i></p>	

RECEIVED
 BALTIMORE
 1900

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN lb 15 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely d. STREET ADDRESS 05X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carroll	4. DATE OF DEATH March 9 1959	5. SEX Male	
6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY md	9. AGE (In years last birthday) 67 yrs.	
11. BIRTHPLACE (State or foreign country) md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Preston Griffin	
14. MOTHER'S MAIDEN NAME Norrietta Sparks	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	
17. INFORMANT Sparks	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple 7 fractures Head & Spine 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Internal Hemorrhage - Shock DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 15 min
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Automobile Accident	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 3-7 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Rural Ridgely Caroline Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dawson D. George		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAWSON D. George		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Grove	22d. LOCATION (City, town, or county) (State) Easton, Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil McCremon		24a. REC'D BY REGISTRAR DATE MAR 13 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. CAUSE OF DEATH: _____

8. MANNER OF DEATH: _____

9. SIGNATURE OF MEDICAL EXAMINER: _____

10. DATE: _____

11. TIME: _____

12. PLACE: _____

13. SIGNATURE OF REGISTRAR: _____

14. DATE: _____

15. TIME: _____

16. PLACE: _____

17. SIGNATURE OF WITNESS: _____

18. DATE: _____

19. TIME: _____

20. PLACE: _____

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
3578 CERTIFICATE OF DEATH														
Reg. Dist. No. 03553														
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Talbot									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman's Island					c. LENGTH OF STAY IN 1b X					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman's Island				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Avalon P.O.					d. STREET ADDRESS Avalon, P.O.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Frank Middle H Last Grill					4. DATE OF DEATH Month March Day 20 Year 19 59									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1893		9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Maker					10b. KIND OF BUSINESS OR INDUSTRY Blind Work Shop					11. BIRTHPLACE (State or foreign country) Providence, R.I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Grill					14. MOTHER'S MAIDEN NAME Pauline Wiegand									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. W.W.1 217-07-7011		INFORMANT Anna C. Grill		Address Same.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Alcoholism, (Exhaustion) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Alcoholism, (Exhaustion) (c) DUE TO Alcoholism, (Exhaustion)										INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 19 55 to March 20, 19 59 that I last saw the deceased alive on March 19, 19 59 and that death occurred at C30 from the causes and on the date stated above. ADDRESS (Street, city or town, state) Tilghman's Island DATE SIGNED March 23, 19 59														
ACTUAL SIGNATURE GUY M REESER					M.D. Tilghman's Island									
PHYSICIAN'S NAME (Type) GUY M REESER														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 3-23-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			22d. LOCATION (City, town, or county) (State) E. North Ave. Balto., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Seiler					ADDRESS 9015 CONKLING ST. BALTO. MD		24a. REC'D BY REGISTRAR MAR 23 59			24b. REGISTRAR'S SIGNATURE Arthur S. Harris				

RECEIVED

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[Faint, illegible handwritten text, possibly a signature or address, covering the lower half of the page.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V8. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03554

1. PLACE OF DEATH a. COUNTY <u>Easton Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 164 Rt. 2</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
3. NAME OF DECEASED (Type or print) <u>Gregory Oneal Hensley</u>		f. STREET ADDRESS <u>Box 164 Rt. 2</u>	
4. DATE OF DEATH <u>3</u> <u>22</u> <u>19 59</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/54</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Carroll Hensley</u>		16. MOTHER'S MAIDEN NAME <u>Mary L. Campher</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT <u>Mary H. Campher, Trappe, Md.</u>		Address	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sickle cell anemia</u> <u>292.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>292.6</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis Wherry</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WEKTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. RACE: _____

5. OCCUPATION: _____

6. PLACE OF BIRTH: _____

7. DATE OF BIRTH: _____

8. DATE OF DEATH: _____

9. TIME OF DEATH: _____

10. PLACE OF DEATH: _____

11. CAUSE OF DEATH: _____

12. MANNER OF DEATH: _____

13. SIGNATURE OF EXAMINER: _____

14. TITLE OF EXAMINER: _____

15. DATE OF EXAMINATION: _____

16. SIGNATURE OF WITNESS: _____

17. TITLE OF WITNESS: _____

18. DATE OF WITNESSING: _____

19. SIGNATURE OF CORONER: _____

20. TITLE OF CORONER: _____

21. DATE OF CORONER'S SIGNATURE: _____

22. SIGNATURE OF JURY: _____

23. TITLE OF JURY: _____

24. DATE OF JURY'S SIGNATURE: _____

25. SIGNATURE OF JUDGE: _____

26. TITLE OF JUDGE: _____

27. DATE OF JUDGE'S SIGNATURE: _____

28. SIGNATURE OF CLERK: _____

29. TITLE OF CLERK: _____

30. DATE OF CLERK'S SIGNATURE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3555

CERTIFICATE OF DEATH

Reg. Dist. No.

03555

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>8 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>17x-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oakley KERSEY Higdon</u>		4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Higdon</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Clayton Clifton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-5061</u>	
17. INFORMANT <u>Mr. Warren C. Higdon</u>		Address <u>Queen Anne, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior Coronary Thrombosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmitt</u> M.D.		DATE SIGNED <u>219 5. Washington St 15 MAR 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>March 17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Schmitt</u> ADDRESS <u>1300 B. W. Centerville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3556

CERTIFICATE OF DEATH

Reg. Dist. No.

03556

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				1d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William D. Jackson</u>				4. DATE OF DEATH Month Day Year <u>March 30 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3 1964</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET BRIDGE TENDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BRIDGE TENDER</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Noah Jackson</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH CUMMINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MISS BERTHA JACKSON, ST. MICHAELS, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial failure -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic cardiovascular d.</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24/59</u> , 19 <u>59</u> , to <u>3/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>59</u> , and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>3-30-59</u>							
ACTUAL SIGNATURE <u>Guy M. Beecher</u> M.D.				PHYSICIAN'S NAME (Type) <u>Guy M Beecher M.D.</u> <u>St Michaels Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hamilton Harrison</u> ADDRESS <u>St Michaels, Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

CERTIFICATE OF DEATH

03557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Lewis</u> Middle <u>B</u> Last				4. DATE OF DEATH <u>March 8</u> Month <u>12</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7 1886</u> yrs. <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Cheezum</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. FREDERICK E. LEWIS</u> Address <u>EASTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 <u>59</u> to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Al Cox</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll</u> ADDRESS <u>EASTON, MD.</u>				24a. REC'D BY REGISTRAR <u>APR 1 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5553

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF DECEASED <i>None</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one code]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.1 DUE TO
Conditions, if any, which } (b)
gave rise to immediate }
cause (a), stating the under } DUE TO
lying cause lost. } (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. f. 1.
p. m. 19

20d. INJURY OCCURRED
While Not while
of work of work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(Slot)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on February 2, 1958, and that death occurred at 5:30 AM, from the causes and on the date stated above.

**ACTUAL
SIGNATURE**

PHYSICIAN'S
NAME (Type)

M.D.

ADDRESS (Street, city or town, state)

DATE SIGN: _____

220. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAR 1 2 '59

Arthur S. Kraus

CERTIFICATE OF DEATH

Reg. Dist. No.

03559

3559

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 30 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) Dover St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last MERRICK				4. DATE OF DEATH Month March Day 30 Year 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1924		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Griffin Merrick				14. MOTHER'S MAIDEN NAME Neva LeCompte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-16-7494		17. INFORMANT Mrs. Neva Merrick Address Dover St. Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/29/1959 , to 3/29/1959 , that I last saw the deceased alive on 3/29/1959 , and that death occurred at 11:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE P. Cox M.D. PHYSICIAN'S NAME (Type) Dr. P. Evans Cox Easton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

3560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Taylor</u> Last <u>Messix</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1915</u>		9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Messix</u>				14. MOTHER'S MAIDEN NAME <u>Norma Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>Mrs. Hazel Messix - wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meets criteria myocardial</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adobe posttraumatic myocardial infarct.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Sotnick</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Washington St 15 Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Sotnick</u>				DATE SIGNED <u>Easton 16 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Caudle</u> ADDRESS <u>EASTON MD</u>				24a. REC'D BY REGISTRAR <u>DATE APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

3561 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 1 Film G239 3-16-59 et
 CERTIFICATE OF DEATH

Reg. Dist. No.

03561

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>MORRIS ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harvion</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27, 1884</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				Months		Days	
				Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Patrick Mills</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Robbins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Mr. Mary Mills, wife - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>							
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/1, 1958</u> to <u>3/6, 1959</u> , that I last saw the deceased alive on <u>3/6, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. J. Egler</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hillboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u> ADDRESS <u>1501 Easton, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

3251

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1918	
NAME OF DECEASED [illegible]		SEX [illegible]	
AGE [illegible]		OCCUPATION [illegible]	
PLACE OF BIRTH [illegible]		PLACE OF DEATH [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]	
TIME OF DEATH [illegible]		PLACE OF INTERMENT [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]	
CERTIFICATE NO. [illegible]		COUNTY [illegible]	

1

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 1918

03562

3580

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virgie</u> First Middle Last <u>Moore</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/1898</u>	
9. AGE (In years last birthday) <u>70 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charley Handy</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Handy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Anna Jerry Royal Oak, Md.</u>	
17. INFORMANT <u>Anna Jerry Royal Oak, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Hypertensive Cardiovascular Dis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>2 days</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Feb</u> , 19 <u>59</u> , to <u>12 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 Feb</u> , 19 <u>59</u> , and that death occurred at <u>7:45 A</u> .M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wright</u>		DATE SIGNED <u>4 March</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>3/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Royal Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Royal Oak Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Smith</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>	
ADDRESS <u>Cotter, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

03563

3581

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle FRANCIS Last MOORE		4. DATE OF DEATH Month 5 Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) civil engineer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter R. Moore		14. MOTHER'S MAIDEN NAME Mary E. Johns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. 1	
17. INFORMANT Mrs. Catherine Valliant		Address Bellevue, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3-19 , 19 57 , to 3-26 , 19 59 , that I last saw the deceased alive on 3-19 , 19 59 , and that death occurred at 8:00 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Winters		ADDRESS (Street, city or town, state) Easton, Maryland	
PHYSICIAN'S NAME (Type) Dr. Wm. L. Winters		DATE SIGNED 3/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24a. REC'D BY REGISTRAR DATE APR 1 '59	
ADDRESS Easton, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN 1b <u>4 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD #1 Box 126 Preston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>NEAR MT. PLEASANT</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 17, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT GREEN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN JANE (LAST NAME UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS. RUTH SHARP - PHILADELPHIA 19, PA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cause undetermined</u> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. W. E. H. T. V.</u>		DATE SIGNED <u>3-11-59</u>	
EXAMINER'S NAME (Type) <u>W. E. H. T. V.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NEAR PRESTON, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u>		24a. REC'D BY REGISTRAR <u>MAR 17 '59</u>	
ADDRESS <u>1400 Federalburg, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

PLACE HERE
A PHOTOGRAPH

5-58

MASSACHUSETTS
STATE DEPARTMENT OF
HEALTH
MEDICAL EXAMINER'S
CERTIFICATE OF DEATH

7

DATE OF DEATH
PLACE HERE
A PHOTOGRAPH

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A PHOTOGRAPH

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A PHOTOGRAPH

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A PHOTOGRAPH

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A PHOTOGRAPH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03565

3582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST MICHAELS MD</u>				c. LENGTH OF STAY IN 1b <u>12 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>C.</u> Last <u>NEWNAM SR.</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>CHARLES NEWNAM</u>				14. MOTHER'S MAIDEN NAME <u>LULU WILLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>George C. Newnam Jr. St. Michaels Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cachexia severe-generalized</u> DUE TO (c) <u>adenocarcinoma stomach</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>with multiple metastases-M1-Liver</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6-1-58</u> , to <u>3-19-59</u> , that I last saw the deceased alive on <u>3-19-59</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thym B. Reeder</u>				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
PHYSICIAN'S NAME (Type) <u>Thym B. Reeder</u>				DATE SIGNED <u>3-20-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heavitt Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Heavitt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Harrison</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>	

3583

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural St. Michaels				c. LENGTH OF STAY in 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe, Maryland			
f. STREET ADDRESS Main St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAURICE EVEREST NEWMAN				4. DATE OF DEATH Month Day Year Mar. 10, 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1874		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME William B. Newnam			
14. MOTHER'S MAIDEN NAME Edith Parsons				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 214-34-7421				17. INFORMANT Mrs. Maurice Newnam, Sr. Address Trappe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cardiac and DUE TO (c) cerebrovascular d PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia - chronic, cachexia generalized INTERVAL BETWEEN ONSET AND DEATH 10 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8-3 , 1956 , to 3-10 , 1959 , that I last saw the deceased alive on 3-10 , 1959 , and that death occurred at 11:54 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Guy M. Reeser, Jr.				ADDRESS (Street, city or town, state) St. Michaels, Md.			
DATE SIGNED 3-13-59				M.D.			
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.				ST. MICHAELS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR MAR 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms							

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3584

CERTIFICATE OF DEATH

03567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural St. Michaels</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rio Vista Nursing Home</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Almira</i> Middle <i>Francis</i> Last <i>Orme</i>		4. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1880</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Selected Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.-9.</i>	
13. FATHER'S NAME <i>S. Percy Stevens</i>		14. MOTHER'S MAIDEN NAME <i>Francis Almira Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>E. J. Orme</i>		Address <i>Denton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral hemorrhage</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>2 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>atherosclerotic cardiocerebrovas. d.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-27</i> 19 <i>59</i> , to <i>3-12</i> 19 <i>59</i> , that I last saw the deceased alive on <i>3-12</i> 19 <i>59</i> , and that death occurred at <i>10 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hubert M. Reeser Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>St Michaels Md</i>	
PHYSICIAN'S NAME (Type) <i>Hubert M. Reeser Jr.</i>		DATE SIGNED <i>3-13-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>		22b. DATE THEREOF <i>Feb 15 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Denton</i>		22d. LOCATION (City, town, or county) (State) <i>Denton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter East</i> ADDRESS <i>Denton Md</i>		24a. REC'D BY REGISTRAR <i>MAR 16 59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles Frederick</i>		SEX Male		AGE 45		DATE OF BIRTH 1870	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		MARITAL STATUS Single		COLOR White	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Baltimore, Md.		DATE OF DEATH 1915		TIME OF DEATH 10:00 AM	
SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		SIGNATURE OF CORONER <i>James B. Jones</i>		SIGNATURE OF WITNESS <i>Robert C. Brown</i>		SIGNATURE OF WITNESS <i>William D. Green</i>	
COUNTY Baltimore		CITY Baltimore		STATE Maryland		YEAR 1915	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Postel</u> Last <u>Postel</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mech. Engineering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Postel</u>		14. MOTHER'S MAIDEN NAME <u>Elnetinc Reiner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>086-01-4826</u>	
17. INFORMANT Address <u>Theodore Postel</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> 550.1 DUE TO <u>Ruptured appendical abscess</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>219 S. Washington St. 12 Mar 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton Md, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ocean View</u>	22d. LOCATION (City, town, or county) (State) <u>Staten Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Boulton</u>		ADDRESS <u>Greenboro Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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3564
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03569

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Groesville 17x-2</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Deaherty "Dorty" Price</u> First Middle Last		4. DATE OF DEATH <u>March 29 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16 1917</u> 41 yrs.
9. AGE (In years last birthday) <u>41</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optic Shucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Percy Price</u>		14. MOTHER'S MAIDEN NAME <u>Virgie Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-07-1755</u>	
17. INFORMANT <u>Fannie Price</u> Address <u>Groesville W.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hard Failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive nephrosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>2195 Washington St 791659</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton 16 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 2 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butts Jr</u> ADDRESS <u>Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3565

CERTIFICATE OF DEATH

Reg. Dist. No.

03570

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton. - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ezekiel</u> Middle <u>Reed</u> Last <u>Reed</u>			4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19, 1878</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A J Reed</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. HARRY M. EVANS, Jr., Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4343</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhagic peri-carditis</u> DUE TO (c) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/25/1959</u> , 19 <u>59</u> , to <u>3/31/1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/31/1959</u> , 19 <u>59</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Vauxhall St. Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>29 March 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hampton Harrison</u>				ADDRESS <u>St. Michaels</u>		24b. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>	
				24c. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3566 CERTIFICATE OF DEATH

03571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 78yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 N. Locust St.			
d. STREET ADDRESS 119 N. Locust St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Flynn Roe				4. DATE OF DEATH Month Day Year March 24 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist				10b. KIND OF BUSINESS OR INDUSTRY Florist-owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles H. Flynn				14. MOTHER'S MAIDEN NAME Luraina Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. 214034-6038			
17. INFORMANT Mrs. Alfred G. McKewen				Address 119 N. Locust St. Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma toxis 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Right Breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/29, 1952 to 3/23, 1959 , that I last saw the deceased alive on 3/23, 1959 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Shepard K. Krech, Jr.				ADDRESS (Street, city or town, state) EASTON			
PHYSICIAN'S NAME (Type) SHEPARD KRECH, JR.				DATE SIGNED 3/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/26/58		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Easton, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR APR 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3567

CERTIFICATE OF DEATH

Reg. Dist. No.

03572

1. PLACE OF DEATH a. COUNTY <u>LALBET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN lb <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>		05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Odelle</u> Last <u>Saulsbury</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wk</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16/73</u>	9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ABRAHAM WRIGHT</u>			14. MOTHER'S MAIDEN NAME <u>AMANDA HITCH</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subcut of right kidney</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE _____ M.D. <u>219 S. Washington St. N.W.</u> PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> <u>Easton 16, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>1) Centon</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. ...</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3568

CERTIFICATE OF DEATH

03573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>2ALbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Castle Delaware 46 X-3 ✓</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>124 Stalhove Wilmington Mar</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>SHARP</u> Last <u>SHARP</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Luke Wooters</u>				14. MOTHER'S MAIDEN NAME <u>Martha Kirkman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>XXX</u>		17. INFORMANT <u>Raymond Sharp</u> Address <u>New Castle Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis, left middle cerebral artery</u> <u>332X</u> DUE TO (b) <u>5 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>332X</u> DUE TO (b) <u>5 days</u> DUE TO (c) <u>5 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of the sigmoid colon</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>59</u> , to <u>3-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>3-31-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.				DATE SIGNED <u>3-31-59</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>				Easton Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman, Jr.</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

3582

PLACE IN DEATH		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
1		2		3		4		5		6		7		8		9		10		11	
12		13		14		15		16		17		18		19		20		21		22	
23		24		25		26		27		28		29		30		31		32		33	
34		35		36		37		38		39		40		41		42		43		44	
45		46		47		48		49		50		51		52		53		54		55	
56		57		58		59		60		61		62		63		64		65		66	
67		68		69		70		71		72		73		74		75		76		77	
78		79		80		81		82		83		84		85		86		87		88	
89		90		91		92		93		94		95		96		97		98		99	
100		101		102		103		104		105		106		107		108		109		110	
111		112		113		114		115		116		117		118		119		120		121	
122		123		124		125		126		127		128		129		130		131		132	
133		134		135		136		137		138		139		140		141		142		143	
144		145		146		147		148		149		150		151		152		153		154	
155		156		157		158		159		160		161		162		163		164		165	
166		167		168		169		170		171		172		173		174		175		176	
177		178		179		180		181		182		183		184		185		186		187	
188		189		190		191		192		193		194		195		196		197		198	
199		200		201		202		203		204		205		206		207		208		209	
210		211		212		213		214		215		216		217		218		219		220	
221		222		223		224		225		226		227		228		229		230		231	
232		233		234		235		236		237		238		239		240		241		242	
243		244		245		246		247		248		249		250		251		252		253	
254		255		256		257		258		259		260		261		262		263		264	
265		266		267		268		269		270		271		272		273		274		275	
276		277		278		279		280		281		282		283		284		285		286	
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309		310		311		312		313		314		315		316		317		318		319	
320		321		322		323		324		325		326		327		328		329		330	
331		332		333		334		335		336		337		338		339		340		341	
342		343		344		345		346		347		348		349		350		351		352	
353		354		355		356		357		358		359		360		361		362		363	
364		365		366		367		368		369		370		371		372		373		374	
375		376		377		378		379		380		381		382		383		384		385	
386		387		388		389		390		391		392		393		394		395		396	
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430		431		432		433		434		435		436		437		438		439		440	
441		442		443		444		445		446		447		448		449		450		451	
452		453		454		455		456		457		458		459		460		461		462	
463		464		465		466		467		468		469		470		471		472		473	
474		475		476		477		478		479		480		481		482		483		484	
485		486		487		488		489		490		491		492		493		494		495	
496		497		498		499		500		501		502		503		504		505		506	
507		508		509		510		511		512		513		514		515		516		517	
518		519		520		521		522		523		524		525		526		527		528	
529		530		531		532		533		534		535		536		537		538		539	
540		541		542		543		544		545		546		547		548		549		550	
551		552		553		554		555		556		557		558		559		560		561	
562		563		564		565		566		567		568		569		570		571		572	
573		574		575		576		577		578		579		580		581		582		583	
584		585		586		587		588		589		590		591		592		593		594	
595		596		597		598		599		600		601		602		603		604		605	
606		607		608		609		610		611		612		613		614		615		616	
617		618		619		620		621		622		623		624		625		626		627	
628		629		630		631		632		633		634		635		636		637		638	
639		640		641		642		643		644		645		646		647		648		649	
650		651		652		653		654		655		656		657		658		659		660	
661		662		663		664		665		666		667		668		669		670		671	
672		673		674		675		676		677		678		679		680		681		682	
683		684		685		686		687		688		689		690		691		692		693	
694		695		696		697		698		699		700		701		702		703		704	
705		706		707		708		709		710		711		712		713		714		715	
716		717		718		719		720		721		722		723		724		725		726	
727		728		729		730		731		732		733		734		735		736		737	
738		739		740		741		742		743		744		745		746		747		748	
749		750		751		752		753		754		755		756		757		758		759	
760		761		762		763		764		765		766		767		768		769		770	
771		772		773		774		775		776		777		778		779		780		781	
782		783		784		785		786		787		788		789		790		791		792	
793		794		795		796		797		798		799		800		801		802		803	
804		805		806		807		808		809		810		811		812		813		814	
815		816		817		818		819		820		821		822		823		824		825	
826		827		828		829		830		831		832		833		834		835		836	
837		838		839		840		841		842		843		844		845		846		847	
848		849		850		851		852		853		854		855		856		857		858	
859		860		861		862		863		864		865		866		867		868		869	
870		871		872		873		874		875		876		877		878		879		880	
881		882		883		884		885		886		887		888		889		890		891	
892		893		894		895		896		897		898		899		900		901		902	
903		904		905		906		907		908		909		910		911		912		913	
914		915		916		917		918		919		920		921		922		923		924	
925		926		927		928		929		930		931		932		933		934		935	
936		937		938		939		940		941		942		943		944		945		946	
947		948		949		950		951		952		953		954		955		956		957	
958		959		960		961		962		963		964		965		966		967		968	
969		970		971		972		973		974		975		976		977		978		979	
980		981		982		983		984		985		986		987		988		989		990	
991		992		993		994		995		996		997		998		999		1000		1001	

1000

3569

CERTIFICATE OF DEATH

Reg. Dist. No.

03574

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Bloomfield Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Thomas</u> Last <u>Swan</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 6, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grain</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Swan</u>				14. MOTHER'S MAIDEN NAME <u>Laura Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-347219</u>		17. INFORMANT <u>Mrs. Anna Swan</u> Address <u>Easton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>E Gendryed Metastasis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/22</u> , 1958, to <u>3/22</u> , 1959, that I last saw the deceased alive on <u>3/22</u> , 1959, and that death occurred at <u>4:59 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>3/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 24, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u> ADDRESS <u>Easton</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

300

1. NAME OF DECEASED <i>William J. Blalock</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>2/2/50</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Coronary Thrombosis</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Washington, D.C.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF WITNESS <i>[Signature]</i>	
19. SIGNATURE OF REGISTRAR <i>[Signature]</i>		20. SIGNATURE OF CLERK <i>[Signature]</i>		21. SIGNATURE OF JURY <i>[Signature]</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3570

CERTIFICATE OF DEATH

04795
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mem. R. H. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>W</u> Last <u>WALLACE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27, 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Ezekiel Whidbee</u>			
14. MOTHER'S MAIDEN NAME <u>MARIA VAN DYKE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>KN</u>				17. INFORMANT <u>MR. THOMAS WALLACE</u> Address <u>SHERWOOD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of Ovary</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>From</u> <u>147.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 1959</u> to <u>22 March 1959</u> , that I last saw the deceased alive on <u>Mar 22, 1959</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.				ADDRESS (Street, city or town, state) <u>Bay 457, St. Michaels, Md</u>			
PHYSICIAN'S NAME (Type) <u>B. LANE WROTH</u>				DATE SIGNED <u>3-23-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SHERWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHERWOOD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. ...</u> ADDRESS <u>...</u>				24a. REC'D BY REGISTRAR <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	
DATE <u>APR 14 '59</u>							

3571

CERTIFICATE OF DEATH

03575

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Easton</u> Md. b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R.F.D. 4.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Webb</u> Middle <u>Webb</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Chase</u>				14. MOTHER'S MAIDEN NAME <u>Louise Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elsie Netter, Easton, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Parenchymatous Nephritis</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <u>—</u> lying cause (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				20g. (County) <u>Talbot</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Nov. 1955</u> to <u>March 22, 1959</u> , that I last saw the deceased alive on <u>March 22, 1959</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Easton, Md.</u>				DATE SIGNED <u>April 3, 1959</u>			
ACTUAL SIGNATURE <u>Haymond G. Holt</u>				M.D.			
PHYSICIAN'S NAME (Type) <u>James B. Doherty</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u>				24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. DATE OF DEATH</p> <p>18. COUNTY</p> <p>19. CITY</p> <p>20. STATE</p> <p>21. ZIP CODE</p> <p>22. SIGNATURE OF WITNESS</p> <p>23. SIGNATURE OF DECEASED</p> <p>24. SIGNATURE OF NEXT OF KIN</p> <p>25. SIGNATURE OF BURIAL SOCIETY</p> <p>26. SIGNATURE OF FUNERAL HOME</p> <p>27. SIGNATURE OF CHURCH</p> <p>28. SIGNATURE OF CEMETERY</p> <p>29. SIGNATURE OF INTERVIEWER</p> <p>30. SIGNATURE OF SUPERVISOR</p> <p>31. SIGNATURE OF ASSISTANT SUPERVISOR</p> <p>32. SIGNATURE OF CLERK</p> <p>33. SIGNATURE OF RECEPTIONIST</p> <p>34. SIGNATURE OF TELEPHONE OPERATOR</p> <p>35. SIGNATURE OF MAIL ROOM</p> <p>36. SIGNATURE OF RECORDS SECTION</p> <p>37. SIGNATURE OF STATISTICS SECTION</p> <p>38. SIGNATURE OF PUBLIC HEALTH SECTION</p> <p>39. SIGNATURE OF LABORATORY SECTION</p> <p>40. SIGNATURE OF RADIOLOGY SECTION</p> <p>41. SIGNATURE OF PATHOLOGY SECTION</p> <p>42. SIGNATURE OF ANATOMY SECTION</p> <p>43. SIGNATURE OF PHYSIOLOGY SECTION</p> <p>44. SIGNATURE OF PSYCHOLOGY SECTION</p> <p>45. SIGNATURE OF SOCIOLOGY SECTION</p> <p>46. SIGNATURE OF ANTHROPOLOGY SECTION</p> <p>47. SIGNATURE OF LINGUISTICS SECTION</p> <p>48. SIGNATURE OF PHILOSOPHY SECTION</p> <p>49. SIGNATURE OF HISTORY SECTION</p> <p>50. SIGNATURE OF GEOGRAPHY SECTION</p> <p>51. SIGNATURE OF POLITICAL SCIENCE SECTION</p> <p>52. SIGNATURE OF ECONOMICS SECTION</p> <p>53. SIGNATURE OF LAW SECTION</p> <p>54. SIGNATURE OF MEDICAL LAW SECTION</p> <p>55. SIGNATURE OF NURSING SECTION</p> <p>56. SIGNATURE OF DENTISTRY SECTION</p> <p>57. SIGNATURE OF VETERINARY SECTION</p> <p>58. SIGNATURE OF AGRICULTURE SECTION</p> <p>59. SIGNATURE OF FISHERIES SECTION</p> <p>60. SIGNATURE OF FORESTRY SECTION</p> <p>61. SIGNATURE OF MINING SECTION</p> <p>62. SIGNATURE OF MANUFACTURING SECTION</p> <p>63. SIGNATURE OF TRANSPORTATION SECTION</p> <p>64. SIGNATURE OF COMMUNICATIONS SECTION</p> <p>65. SIGNATURE OF ENERGY SECTION</p> <p>66. SIGNATURE OF ENVIRONMENTAL SECTION</p> <p>67. SIGNATURE OF SPACE SECTION</p> <p>68. SIGNATURE OF DEFENSE SECTION</p> <p>69. SIGNATURE OF INTELLIGENCE SECTION</p> <p>70. SIGNATURE OF DIPLOMACY SECTION</p> <p>71. SIGNATURE OF CULTURE SECTION</p> <p>72. SIGNATURE OF ARTS SECTION</p> <p>73. SIGNATURE OF LITERATURE SECTION</p> <p>74. SIGNATURE OF MUSIC SECTION</p> <p>75. SIGNATURE OF THEATRE SECTION</p> <p>76. SIGNATURE OF FILM SECTION</p> <p>77. SIGNATURE OF TELEVISION SECTION</p> <p>78. SIGNATURE OF RADIO SECTION</p> <p>79. SIGNATURE OF JOURNALISM SECTION</p> <p>80. SIGNATURE OF PUBLISHING SECTION</p> <p>81. SIGNATURE OF EDUCATION SECTION</p> <p>82. SIGNATURE OF RESEARCH SECTION</p> <p>83. SIGNATURE OF DEVELOPMENT SECTION</p> <p>84. SIGNATURE OF PLANNING SECTION</p> <p>85. SIGNATURE OF MANAGEMENT SECTION</p> <p>86. SIGNATURE OF BUSINESS SECTION</p> <p>87. SIGNATURE OF INDUSTRY SECTION</p> <p>88. SIGNATURE OF LABOR SECTION</p> <p>89. SIGNATURE OF TRADE SECTION</p> <p>90. SIGNATURE OF SERVICE SECTION</p> <p>91. SIGNATURE OF GOVERNMENT SECTION</p> <p>92. SIGNATURE OF NON-PROFIT SECTION</p> <p>93. SIGNATURE OF FOUNDATION SECTION</p> <p>94. SIGNATURE OF ENDOWMENT SECTION</p> <p>95. SIGNATURE OF TRUST SECTION</p> <p>96. SIGNATURE OF ESTATE SECTION</p> <p>97. SIGNATURE OF PROBATE SECTION</p> <p>98. SIGNATURE OF WILL SECTION</p> <p>99. SIGNATURE OF ESTATE PLANNING SECTION</p> <p>100. SIGNATURE OF TAX SECTION</p>	
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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3572

CERTIFICATE OF DEATH

Reg. Dist. No.

03576

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>058-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Vannie</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1881</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Preacher</u>			
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Sam Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Bledsoe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Robertia Frame</u>			
17. INFORMANT <u>Robertia Frame</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infant, right cerebrum</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>March 1, 1959</u> , to <u>March 6, 1959</u> , that I last saw the deceased alive on <u>March 1, 1959</u> , and that death occurred at <u>3:35 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. West 11th St. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>March 11, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cem</u>		22d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel S. Schmidt</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 3573
 CERTIFICATE OF DEATH

03577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>11235. Hanson St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Herman</u> Last <u>Wolf</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 19, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL TECH.</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ERNEST WOLF</u>		14. MOTHER'S MAIDEN NAME <u>UNKN OWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>467 01 1091</u>	
17. INFORMANT <u>JOS. WOLF</u>		Address <u>EASTON MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> (c) <u>Arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-27-</u> , 19 <u>58</u> , to <u>3-24-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 24</u> , 19 <u>59</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9 N. HANSON ST.</u> DATE SIGNED <u>3-25-59</u> ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u> <u>EASTON, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEN. PARK</u>	22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Newman</u> ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

